Department of Veterans Affairs
Veterans Health Administration
Washington, DC 20420

Replaced by VHA Directive 201-060

VHA DIRECECTIVE 97-036
Change 1
October 28, 1997

VETERANS HEALTH ADMINISTRATION POLICY FOR PLANNING AND ACTIVATING COMMUNITY BASED OUTPATIENT CLINICS

1. **PURPOSE:** This change to Veterans Health Administration (VHA) Directive updates the policy for planning and activating new Department of Veterans Affairs (VA) Community Based Outpatient Clinics (CBOCs).

2. **POLICY**: It is VHA policy to provide maximum flexibility for improving the quality of patient care and to increase the efficiency of operations, Veterans Integrated Service Network (VISN) Directors are hereby authorized to establish CBOCs in their jurisdiction with an estimated annual operating cost, including lease, of up to $1 million. Establishment of clinics is subject to the appropriate notification to Congress, the availability of funds within the VISN, and applicable federal statutes and VA regulations. For anything not explicitly discussed in this directive, refer to the issuances listed under paragraph 5, References.

3. **ACTION: Subparagraph 4c(10):** Is changed to read "An assessment of the need for providing basic primary care mental health services."

4. **FOLLOW-UP RESPONSIBILITY**: The Chief Network Officer (10N) and the Chief Policy, Planning and Performance Officer (105) are responsible for the contents of this VHA Directive.

5. **RESCISSION**: This VHA Directive and change 1 will expire July 16, 2002.

S/M.Murphy for
Kenneth W. Kizer, M.D., M.P.H.
Under Secretary for Health

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Department of Veterans Affairs **VHA DIRECECTIVE 97-036**
Veterans Health Administration
Washington, DC 20420 **July 16, 1997**

VETERANS HEALTH ADMINISTRATION POLICY FOR PLANNING AND ACTIVATING COMMUNITY BASED OUTPATIENT CLINICS

1. **PURPOSE:** This Veterans Health Administration (VHA) Directive updates the policy for planning and activating new Department of Veterans Affairs (VA) Community Based Outpatient Clinics (CBOCs) as a result of the passage of the Veterans' Health Care Eligibility Reform Act of 1996, Public Law (Pub. L.) 104-262. The intent of establishing a new presence of outpatient care is to provide more convenient access to care for our currently enrolled users, and to improve access opportunities within existing resources for eligible veterans not currently served.

2. **BACKGROUND**

a. A CBOC is defined as a VA operated clinic (in a fixed location) or a VA funded or reimbursed healthcare facility or site that is geographically distinct or separate from the parent medical facility. A healthcare facility must have the necessary professional medical staff, diagnostic testing and treatment capability, and referral arrangements needed to ensure continuity of healthcare for currently eligible as well as potentially eligible veteran clients.

b. The current legislative authorities relevant to establishing CBOCs are outlined in Attachment A. The Veterans' Health Care Eligibility Reform Act, Pub. L. 104-262, provides significantly enhanced sharing authority to VHA. This legislation authorizes VA to obtain healthcare resources by entering into contracts or other agreements with any healthcare facility, entity, or individual. Generally speaking, this authority may now be used to contract for primary care and/or for a CBOC. VHA Directive 97-015, Expanded Health Care Resources Sharing Authority, should be consulted if and when it is used to contract for a CBOC. Questions concerning use of the enhanced sharing authority may be directed to the Medical Sharing Office (166) in VHA Headquarters.

c. **Reasons for Establishing New Clinics.** The need to establish a new CBOC is to more efficiently and effectively serve eligible veterans, i.e., to provide care in the most appropriate setting. Such clinics will facilitate the transition of VA from a hospital bed-based system of care to a more efficient healthcare system rooted in ambulatory and primary care. Among the specific desirable outcomes and goals which might result and should be pursued from establishing a CBOC are the following:

(1) Improve quality of care by facilitating patient compliance with clinical instructions and continuity of care (because of more convenient access) and by promoting more timely attention to medical problems.

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(2) Shorten hospital length of stay by accomplishing pre-admission work-up or providing post-discharge follow-up care closer to the patient's home.

(3) Reduce the need to travel long distances to receive care, thus reducing beneficiary travel expenditures.

(4) Reduce the distance veterans need to travel in congested urban traffic or inclement weather.

(5) Redirect patients currently served at medical center clinics and thereby shorten waiting times or relieve congestion at these treatment sites.

(6) Reduce fee-basis care (when that would be cost-beneficial).

(7) Shorten waiting times for follow-up care (e.g., post surgical or after hospitalization).

(8) Reduce the operating cost of providing care; i.e., provide care to existing patients at a lower cost by providing it in a community ambulatory care setting rather than a hospital-based clinic.

(9) Reduce the need for home health services because of more accessible follow-up care.

(10) Enhance service delivery by community agencies through improved liaison.

(11) Improve access to care for historically underserved veteran populations.

(12) Improve overall customer satisfaction for current users.

(13) Shift emphasis to prevention, promotion of heath and patient education in contrast to treating patients episodically.

d. While new users of the VA will almost certainly occur as a consequence of establishing a CBOC in an underserved area, these clinics shall not be established solely or primarily for the purpose of attracting new VA patients. Since any new users must be accommodated within existing allocations and treatment priorities, caution should be exercised in this regard in view of VA's constrained resources.

3. **POLICY**: To provide maximum flexibility for improving the quality of patient care and to increase the efficiency of operations, Veterans Integrated Service Network (VISN) Directors are hereby authorized to establish CBOCs in their jurisdiction with an estimated annual operating cost, including lease, of up to $1 million. Establishment of clinics is subject to the appropriate notification to Congress, the availability of funds within the VISN, and applicable federal statutes and VA regulations. For anything not explicitly discussed in this directive, refer to the issuances listed under paragraph 5, References.

4. **ACTION**

a. **Basic Requirements for Establishing CBOCs**. A new clinic must meet the following basic requirements:

(1) Further the strategic objectives of the VHA (as delineated in Vision for Change and Prescription for Change).

(2) Be established in compliance with prevailing legal authorities (see Att. A).

(3) Be established and operated within existing resources and be managed so that the clinic is able to provide care more effectively than can be done through existing settings.

NOTE: *Funding and staffing for new CBOCs will have to come entirely from resources expected to be available to the facility or Network. Through a cooperative process, Networks can identify part of their allocated budgets for developing and operating new CBOCs without exceeding available funds. Funding and staffing needed to provide for new workload must also come from existing Network resources***.**

(4) Serve an underserved population of eligible veterans. In considering the clinics' projected workload, preference shall be given to existing priorities for access to VA care.

(5) See Attachment B, Desirable Characteristics of a Community Based Outpatient Clinic.

b. Although CBOCs should be located within VISN boundaries, VISN Directors are encouraged to consider joint planning and/or clinic initiatives to serve veteran populations residing in areas near the boundaries between two VISNs. Any proposed boundary changes, as well as any proposals which would locate a new clinic across boundaries or in close proximity to a VISN border, must be agreed to by all affected VISN Directors and documentation of such an agreement must be submitted with the clinic proposal.

c. All plans to establish new clinics or realign existing ones must be referenced in the annual VISN business/strategic plan. Because specific towns referenced may need to be changed as proposals are further developed based on actual local conditions, it is not a requirement to specifically identify individual sites or name the town of the new location in the annual plan. A general description of the proposed location (i.e., county or contiguous counties) is sufficient. Formal proposals for CBOCs must be more specific and must be submitted even if the proposed arrangement would be under a VA-DOD sharing agreement or if new primary care services are being added at an existing Vet center. The following data elements, at a minimum, shall be addressed by the proposal (see Att. C):

(1) A general description of the rationale for establishing the clinic as well as the outcomes to be achieved.

(2) A discussion and analysis of the alternatives which were considered in establishing the clinic.

(3) A detailed description of the target market analysis and proposed workload projections for the CBOC.

(4) A description and/or listing of the major types of medical and non-medical healthcare services to be provided.

(5) A listing and description of the sources of funds and the full-time (FTE) that will be used by the clinic.

(6) A contingency plan for how resource needs will be met or workload limited should new workload substantially exceed what was projected.

(7) An accounting of stakeholder involvement, input and/or comments, and concerns.

(8) An implementation plan, with milestones and timelines, for implementing the clinic once the proposal is approved.

(9) A description of how to evaluate whether the clinic is achieving the business purposes and overall goals and objectives.

d. **Approval Process**

(1) A conceptual proposal to establish a clinic will be developed in the VISN in accordance with the data elements listed in subparagraph 4.c. Finalized lease, VA-DOD agreement, or sharing agreements are not required at this time. However, the proposals must reflect the intent to comply with the legislative and policy requirements pertaining to the acquisition of leased space through a competitive bid process.

(2) A proposal (hard copy) in the format delineated in Attachment C, will be submitted to the Chief Network Officer for review by VHA Headquarters and General Counsel. Recommendations for approval will then be made to the Chief Network Officer.

(3) Following the review in subparagraph d.(2), the Under Secretary for Health will review and if the Under Secretary for Health concurs, will notify the House and Senate Appropriations Subcommittees.

(4) If Congressional comments are offered, the Chief Network Officer will confer as necessary with the Under Secretary for Health and the VISN Director.

(5) Final documents which are subject to headquarters review under established regulations, including any actual lease or sharing agreements above the applicable dollar thresholds, will be submitted for approval (see par. 5 and Att. A). In general, non-competitive sharing agreements below $500,000 (including all option years) and competitive sharing agreements below $1.5 million (including all option years) may be executed without prior legal and technical review by

VHA Headquarters. However, copies of all executed sharing agreements must be sent to the Medical Sharing Office (166) within 5 days of final signature.

5. **REFERENCES**

a. M-9, Chapter 9, Change 4, Attachment 9G, Criteria and Standards for New Outpatient Services Remote from a VA Medical Center.

b. VA Circular 00-90-22, Interim Policies and Procedures in the Acquisition and Administration of Leases.

c. VHA Directive 10-94-057, Expedited Lease Procedure for Acquisition of Space for Primary Care Clinics (PCC) and Other Medically Related Space; Delegation of Lease Approval Authority to Directors VAMCs/VAM&ROCs/VAOPCs.

d. VHA Directive 10-94-100, Guidance for the Implementing of Primary Care in Veterans Health Administration.

e. M-1, Part 1, Chapter 34, Change 1, Section II, Sharing Specialized Medical Resources, Facilities, Equipment and Personnel.

f. VHA Directive 10-95-108, VA Central Office Review Process for Scarce Medical Specialist Services and Specialized Medical Resources Contracts.

g. VHA Directive 97-015, Expanded Health Care Resources Sharing Authority.

6. **FOLLOW-UP RESPONSIBILITY**: The Chief Network Officer (10N) and the Chief Policy, Planning and Performance Officer (105) are responsible for the contents of this VHA Directive.

7. **RESCISSION**: VHA Directive 96-049 is rescinded. This VHA Directive will expire July 16, 2002.

Thomas Garthwaite, M.D. for
Kenneth W. Kizer, M.D., M.P.H.
Under Secretary for Health

Attachments

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ATTACHMENT A

LEGAL AUTHORITIES FOR ESTABLISHING COMMUNITY BASED OUTPATIENT CLINICS

1. Contracting With Non-VA Healthcare Providers.

Community Based Outpatient Clinics (CBOCs)(a.k.a. "access points") may be established by entering into contracts with non-VA healthcare providers to provide certain services to eligible VA beneficiaries. The statutes which would authorize such a contract have specific limitations which are discussed below.

a. **Title 38 United States Code (U.S.C.) § 8153**

NOTE: *This statute authorizes the Department of Veterans Affairs (VA) to obtain healthcare resources by entering into contracts or other agreements with any healthcare provider, or other entity or individual. This is now a broad authority which, in general terms, may be used to contract for primary care services or for a CBOC.*

(1) The term "healthcare resource" includes hospital care and medical services (as those terms are defined in section 1701 of Title 38), any other healthcare service, and any healthcare support or administrative resource.

(2) The term "healthcare providers" includes healthcare plans and insurers and any organizations, institutions, or other entities or individuals who furnish healthcare resources.

(3) Healthcare resources may be obtained from any healthcare providers. To the extent that the resource is obtained from an institution affiliated with the Department in accordance with section 7302 of Title 38, including medical practice groups and other entities associated with affiliated institutions, it may be obtained on a sole-source basis. ***NOTE:*** *However, to the extent that the resource is obtained from a source other than an affiliate or an entity associated with an affiliate, competition must be obtained unless an adequate sole-source justification exists. See directives implementing enhanced sharing authority for further guidance.*

b. **Title 38 U.S.C. § 7409**

NOTE: *This statute authorizes VA to enter into contracts with schools and colleges of medicine, osteopathy, dentistry, podiatry, optometry, nursing, clinics and any other group or individual capable of furnishing scarce medical specialist services in VA facilities*

(1) The services must be provided in a VA facility. Consequently, this authority cannot be used to enter into agreements to establish CBOCs using the facilities of the provider with whom VA intends to contract.

(2) Scarce medical specialists may be contracted with to provide medical services at facilities leased or owned by VA. A facility leased by VA would be considered a VA facility for the purposes of this statute.

c. **Title 38 U.S.C. § 8111**

NOTE: *This statute authorizes VA to enter into agreements with the Department of Defense (DOD) for the sharing of healthcare resources***.**

(1) These agreements may be used to establish CBOCs at DOD facilities using DOD personnel, VA personnel, or a combination of DOD and VA personnel.

(2) The term "healthcare resource" is broadly defined by the statute to include hospital care, medical services, rehabilitative services and "any other healthcare service, and any healthcare support or administrative resource." Under this statute it is possible to provide virtually any kind of healthcare at CBOCs including primary care.

(3) Reimbursement must be based upon a flexible methodology that takes into account local conditions and needs and the actual costs to the providing agency.

(4) Proposed agreements must be submitted for approval to the Under Secretary for Health and the Assistant Secretary of Defense for Health Affairs. Such proposals become effective on the 46th day after receipt by either official unless it is approved or disapproved at an earlier date.

2. Establishing VA Operated Community Based Outpatient Clinics

VA may establish a new outpatient presence by placing VA employees at locations chosen as CBOCs. These locations may be either VA leased space or VA owned space.

a. **Acquisition of Community Based Outpatient Clinics by Lease**

(1) Authority: All proposed Community Based Outpatient Clinics are considered "medically related space" and must be funded locally. Space must be acquired through the competitive lease acquisition procedures. A clinic lease for less than 10,000 occupiable (formerly "net usable") square feet (osf), with an annual rent of less than $300,000, and a term of 3 years or less with termination rights after 2 years may be acquired locally when it is determined not to be a capital lease.

(2) Procedure**:** In conjunction with procedures set forth in VHA Directive 10-94-057, the Simplified (Expedited) Lease Acquisition Procedures may be used to acquire space provided that the action does not exceed thresholds as follows:

(a) The space is 10,000 osf or 100 parking spaces or less;

(b) The average annual rental of the proposed lease (without services) is $100,000 or less;

(c) Space requires minimal special purpose alterations; and

(d) Is determined not to be a capital lease.

b. Prior to lease execution, all leases negotiated locally must receive the review and concurrence of Regional Counsel. All leases in excess of $300,000 in annual rental require authorization by the Congress and must be submitted to VHA Headquarters, Office of Facilities Management (184B), for procurement or a delegation of leasing authority.

ATTACHMENT B

DESIRABLE CHARACTERISTICS OF A COMMUNITY BASED OUTPATIENT CLINIC

Among the specific desirable characteristics of a Community Based Outpatient Clinic (CBOC) that should be considered are the following:

1. Is generally within 30 minutes travel time for the majority of veteran patients who will use the clinic.

2. Is near public parking or provides parking.

3. Is accessible by public transportation or is able to provide voluntary transportation.

4. Is conducive to attracting participation and assistance by the Department of Veterans Affairs (VA) Voluntary Service volunteers and Veteran Service Organizations.

5. Enhances partnership or sharing opportunities with affiliated university or community providers and Department of Defense, Public Health Service or Indian Health Service facilities.

6. Is co-located with a Vet center or VA benefits office.

7. Provides ambulatory care educational opportunities for primary care postgraduate physicians (i.e., residents), medical students and/or allied health personnel.

8. Provides flexible hours of operation (e.g., on evenings or weekends).

9. Allows for enhanced community education functions.

10. Facilitates liaison between community providers and VA caregivers.

11. Provides opportunities for CHAMPUS/Tricare revenue generation while enhancing service to veteran patients.

12. Facilitates early treatment intervention and promotes wellness.

ATTACHMENT C

SAMPLE FORMAT FOR PROPOSED COMMUNITY BASED OUTPATIENT CLINIC (CBOC)

Clinic Proposed by: VISN #

Proposed Clinic Location: Proposed location such as county, town or city. A specific street location should not be given because this implies pre-selection of the site. If a proposal addresses more than one site, each site must be specifically identified.

Further Information Contact: Name, address, telephone and fax number of person (s) to contact for additional information. The designated person(s) should be able to answer specific questions about the proposal.

1. **Business Purposes, Goals and Expected Outcomes from Activating this CBOC.** A general description of the rationale for establishing the clinic as well as the outcomes to be achieved. Refer to the Policy and Action sections of the Directive, although the suggested goals and outcomes should not be quoted verbatim in the proposal.

2. **Discussion and Analysis of Alternative Approaches to Delivering Needed Services.** Describe why current Department of Veterans Affairs (VA) assets cannot accommodate the needs of veterans who reside in this service area. Need to describe clearly and give specifics as to what alternatives were considered, including existing Veterans Integrated Service Network (VISN) facilities, contractual arrangements, cost comparison information, etc. If the proposal is for capitation, there needs to be an explanation as to how the rate was determined. As a final paragraph in this section, state which alternative was selected (and described in the proposal) and why.

3. **Demographic Analysis/Projected Workload.** Discuss target market analysis and proposed workload projections for the CBOC. At a minimum, the following data and information would be helpful:

a. Demographic (e.g., veteran population, age distribution of veterans, annual income, ethnicity, economic growth, location of veterans and proximity to parent facility or major cities, transportation issues, etc.)

b. How many veterans will be treated in this CBOC (include 'existing veterans' (uniques) to be re-directed from parent facility as well as projected 'new veterans'). This should be projected for a 2- to 3-year period and the methodology should be explained. If possible, segment "mandatory" (Category A) and discretionary care veterans.

c. How many veterans will be eligible for enrollment in the clinic.

d. How many visits will these veterans generate (per unique), projected for 2 to 3-year period. (Show uniques and visits in a table.)

e. Current market penetration.

f. Whether this is an officially designated manpower shortage area.

NOTE: *Where appropriate, the previous data would be most useful if provided in a table in the body of the proposal rather than as an attachment. Maps showing the location of the proposed clinic and the counties and/or towns being served would be helpful.*

4. **Description of Services to be Provided.** List major types of medical (e.g., primary care, mental health services, EKG, etc.) and non-medical (e.g., social work, benefits counseling, etc.) healthcare services to be provided in this CBOC. Include sufficient detail to describe what will be and what will not be done at the clinic. Discuss the lines of authority and/or accountability for the clinic operation. Also, describe the referral relationship between this CBOC and its "parent" medical center. Include a discussion of how the CBOC will handle after hours and emergency care.

NOTE: *It would be extremely helpful to show what both VA and the Contractor will provide; it needs to be specific as far as services. This involves such issues as how to provide for such services as x-ray, lab, pharmacy, etc.*

5. **Clinic Costs**

a. Remembering that costs for this CBOC must be absorbed from within existing resources available to the VISN, specify as precisely as possible the sources of funds and FTEE that will be used at the CBOC. If new workload is anticipated, describe the planned approach to dealing with this increase and the source of funds to support it.

b. The following costs should be included, where appropriate, and portrayed in tabular form whenever possible:

(1) Staffing by number, type and projected cost for 3 fiscal years (separate the fiscal years).

(2) Specific details regarding any lease or capital costs and, understanding that capital costs must be absorbed from within available resources, project capital costs for 3 years.

(3) All anticipated costs for construction, lease, major equipment and any other significant capital items that support the CBOC.

(4) All recurring costs to include supplies, utilities, etc.

(5) Start-up costs to establish the clinic.

NOTE: *Display, in tabular form, start-up costs, recurring costs, and non-recurring costs for a 3-year period; what is included in each cost should be specified.*

(6) Cost per visit.

(7) Cost per unique veteran.

6. **Contingency Plan for Over-Capacity Workload.** Describe how "new workload" will be limited or managed if it exceeds plans or projections. Consider and, if appropriate, describe such examples as: resource/FTE shifts from the parent facility, attrition, case management and efficiencies such as reduced Bed Days of Care (BDOC) allowing for increases in outpatient workload.

7. **Stakeholder Involvement Report.** Describe involvement of stakeholder groups in the service areas of the proposed CBOC, as well as any future involvement anticipated in supporting the proposal for the CBOC. Simply outline, in chronological format, what has been done or is planned with regard to notifying and involving stakeholders. Insofar as possible, give the type of meeting (e g., town hall, Veterans Service Organizations, community forums, etc.).

8. **Implementation Plan.** Detail the plans for implementing the clinic once the proposal is approved. Provide a timeline, not specific dates, for the processes/activities which need to occur in order for the CBOC to open.

9. **Evaluation Plan.** Describe the parent facility's plan to evaluate how the CBOC is achieving the business purposes and overall goals and objectives discussed in paragraph 1 of the proposal. Discuss how the VISN will coordinate this effort to ensure that the same minimal criteria are evaluated throughout the VISN. Include a discussion of specific performance measures to be used in managing the CBOC and assessing its effectiveness.